DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

W-0168-001

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 49G067 | A. BUILDING 01 - BUILDING 1<br>B. WING _____ | 04/11/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALTAVISTA GROUP HOME | 101 AVOCA LANE<br>ALTAVISTA, VA 24517 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>Surveyor: 34730<br><br>Construction type: V(000)<br><br>Description of structure: Two story.<br><br>Sprinkler status: Partially sprinklered with NFPA 13R system supplied by municipal water.<br><br>An unannounced recertification Life Safety Code survey was conducted 04/11/2017 in accordance with 42 Code of Federal Regulation, Part 483.150 and 410 to 480: Requirements for Intermediate Care Facilities for Persons with Intellectual Difficulties . The facility was surveyed for compliance using the LSC 2012 (Existing) regulations. The facility was not in compliance with the Requirements for Participation for Medicare and Medicaid.<br><br>The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.470 et seq (Physical Environment) | K 000 | *K0511 Issue 1: Monthly Generator Maintenance*<br><br>1. **Address the corrective action taken for identified problem**<br>a Since 9/16 the Monthly Required run and transfer test have been kept up to date with the implementation of the Safety Coordinator position and that Monthly's are documented in the generator log and verified weekly during the Required Visual inspection.<br>b. Forms for documentation were developed to include all required components<br>2. **Address how facility will identify similar occurrences of the problem**<br>a. Monthly run test was done on 04/11/2016 and weekly inspections will be completed by Horizon Behavioral Health's Safety Coordinator Assistant &Coordinator of Physical Plant and Facilities<br>b. Proper documentation of the tests/inspections will be done in the Generator log book<br>3. **Identify measures/systemic changes to ensure deficient practices will not occur**<br>a. Monthly Generator test and inspections will be completed by Horizon Behavioral Health's Safety Coordinator Assistant &Coordinator of Physical Plant and Facilities<br>4. **Indicate how facility will monitor its performance**<br>a. The Residential Manager will monitor to ensure that all weekly/monthly tests and inspections occur and are documented in the Generator log book available at the facility.<br>b. The Residential Manager will do weekly audit of the Generator log book to ensure all documentation is in place<br>5. **Date of correction, not to exceed 45th day after the survey**<br>a. Monthly/weekly inspections and audits of documentation were done on 4/11/17 | 4/11/17 |
| K0511 | NFPA 101 Utilities - Gas and Electric<br><br>Utilities – Gas and Electric<br>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code.<br>32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2<br><br>This Standard is not met as evidenced by:<br>Surveyor: 34730<br>Based on observation and inspection the facility failed to maintain the generator system. This has the ability to affect all occupants of the building. | K0511 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Stephani McClure, Res. Manager | Horizon BH | 4/20/17 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| K0511 | Continued From page 1<br>Findings include:<br><br>On 4-11-17 at approximately 10:00 am during the record review it was observed through observation and inspection that the facility could not provide documentation to show that a monthly 30 minute run test was preformed for September 2016.<br><br>The Facility Administrator witnessed this evidence by observation and interview. | K0511 | *K0741 Issue: Unapproved smoking receptacle in use in the designated smoking when an approved smoking receptacle is provided.*<br><br>**1. Address the corrective action taken for identified problem**<br>a. Unapproved smoking receptacle was removed and disposed of on 4/11/17<br>b. All current staff will be trained on the use of the approved smoking receptacle by 04/18/17 and all new hires will be trained<br><br>**2. Address how facility will identify similar occurrences of the problem**<br>a. The Residential Manager will conduct weekly monitoring of the smoking area to ensure that approved smoking receptacle is being used properly. The Residential Manager will ensure that there is no unapproved receptacle put in place by staff.<br>b. Horizon Behavioral Health's Safety Coordinator Assistant &Coordinator of Physical Plant and Facilities will also conduct weekly monitoring of the smoking area and report any findings to Residential Manager<br><br>**3. Identify measures/systemic changes to ensure deficient practices will not occur**<br>a. Horizon Behavioral Health's Safety Coordinator Assistant &Coordinator of Physical Plant and Facilities will also monitor the smoking area and report any finding to Residential Manager<br>b. The Residential Manager will conduct weekly monitoring of the smoking area<br>c. Residential Manager will educate all staff on Horizon Behavior Health's smoking policy and new hires will be oriented to the policy<br>d. All staff will be trained on the use of the importance of using the approved receptacle<br><br>**4. Indicate how facility will monitor its performance**<br>a. Residential Manager will monitor to ensure the approved receptacle is being used and no unapproved receptacle is in place<br>b. Horizon Behavioral Health's Safety Coordinator Assistant &Coordinator of Physical Plant and Facilities will also monitor the smoking area and report any finding to Residential Manager<br><br>**5. Date of correction, not to exceed 45th day after the survey**<br>a. Un approved receptacle was removed and disposed on 04/11/2017 and Residential Manager will educate all staff by 4/18/17 | 4/18/17 |
| K0741 | NFPA 101 Smoking Regulations<br><br>Smoking Regulations<br>Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations.<br>32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2<br><br>This Standard is not met as evidenced by:<br>Surveyor: 34730<br>Based on observation and inspection the facility failed to maintain smoking regulations. This has the ability to affect all employees and visitors to the facility.<br><br>Findings include:<br><br>On 4-11-17 at approximately 10:25 am it was observed through observation and inspection that an unapproved smoking receptacle is in use in the designated smoking area when an approved smoking receptacle in provided.<br><br>The Facility Administrator witnessed this evidence by inspection and interview. | K0741 | | |